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UNITED NATIONS POPULATION FUND
PROPOSED PROJECTS AND PROGRAMMES

Recommendation by the Executive Director
Assistance to the Government of Zimbabwe

Proposed UNFPA assistance:	$18 million, $8 from regular resources and $10 million through co-financing modalities and/or other, including regular, resources
Programme period:	5 years (2000-2004)
Cycle of assistance:	Fourth
Category per decision 96/15:	B

Proposed assistance by core programme area (in millions of $):

	Regular resources	Other	Total
Reproductive health	6.5	8.5	15.0
Advocacy	1.0	1.5	2.5
Programme coordination and assistance	0.5	-	0.5
Total	8.0	10.0	18.0

ZIMBABWE

INDICATORS RELATED TO ICPD GOALS*

		Thresholds*
Births attended by health professional (%)[1]	70.0	≥60
Contraceptive prevalence rate (15-44) (%)[2]	43.0	≥55
Access to basic health services (%)[3]	85.0	≥60
Infant mortality rate (/1000)[4]	67	≤50
Maternal mortality ratio (/100,000)[5]	570	≤100
Gross female enrolment rate at primary level (%)[6]	84.0	≥75
Adult female literacy rate(%)[7]	76.5	≥50

*** AS CONTAINED IN DOCUMENT DP/FPA/1996/15 AND APPROVED BY THE EXECUTIVE BOARD IN DECISION 96/15.**

[1] *WHO, Coverage of Maternal Care, 3rd ed., 1993. Data cover the period 1983-1993.*

[2] *United Nations Population Division, World Contraceptive Use 1994, ST/ESA/SER.A/143. Data cover the period 1986-1993.*

[3] *UNICEF, The State of the World's Children, 1995. Data cover the period 1985-1993.*

[4] *United Nations Population Division, World Population Prospects Database 1950-2050, 1994 Revision. Data are for 1992.*

[5] *United Nations ACC Task Force on Basic Social Services for All, Wall Chart on Basic Social Services for All, 1997. Government data indicate a ratio of 395 per 100,000 live births.*

[6] *United Nations Statistical Division, Women's Indicators and Statistics Database, Version 3 (CD-ROM), 1994, which is based on data compiled by UNESCO.*

[7] *UNESCO, 1996, Education for All: Achieving the Goal: Statistical Document.*

Demographic Facts

Population (000) in 2000	11,669	Annual population growth rate (%)	0.97
Population in year 2015 (000)	13,572	Total fertility rate (/woman)	3.36
Sex ratio (/100 females)	98.7	Life expectancy at birth (years)	
Age distribution (%)		Males	41.0
Ages 0-14	41.3	Females	41.4
Youth (15-24)	22.0	Both sexes	41.2
Ages 60+	4.2	GNP per capita (U.S. dollars, 1997)	720

Sources: Data are from the Population Division, Department of Economic and Social Affairs of the United Nations, World Population Prospects: The 1998 Revision; GNP per capita is from the World Bank.

N.B. The data in this fact sheet may vary from the data presented in the text of the document.

1. The United Nations Population Fund (UNFPA) proposes to support a population programme over the period 2000-2004 to assist the Government of Zimbabwe in achieving its population and development objectives. UNFPA proposes to fund the programme in the amount of $18 million, of which $8 million would be programmed from UNFPA regular resources to the extent such resources are available. UNFPA would seek to provide the balance of $10 million through co-financing modalities and/or other, including regular, resources to the extent possible, consistent with Executive Board decision 96/15 on the allocation of UNFPA resources. This would be the Fund's fourth programme of assistance to Zimbabwe. Zimbabwe is a "Category B" country under the UNFPA resource allocation criteria.

2. The proposed programme was formulated in close consultation with governmental, non-governmental, United Nations and donor organizations and takes into account the objectives and priorities expressed in the Strategic Rolling Plan of the Ministry of Health and Child Welfare (MOHCW) and the long-term development goals of the Government of Zimbabwe including those delineated in the National Population Policy adopted in 1998. The proposed programme is based on the findings of the UNFPA Country Population Assessment (CPA) exercise conducted in 1999 and the Common Country Assessment (CCA), and is consistent with the United Nations Development Assistance Framework (UNDAF). National experts were closely involved in the CPA exercise. The UNDAF exercise has proved to be a positive experience and has stimulated several collaborative inter-agency activities, including joint field visits, thematic groups, UNDAF-related retreats, a training workshop for journalists, the exchange of work plans and joint quarterly reports. Also under way is a study of the capacity of non-governmental organizations (NGOs). The proposed programme is harmonized with the programmes of UNDP and UNICEF. Programmes supported by WHO, the World Bank and FAO are also expected to begin in the year 2000.

3. The UNDAF, covering the period 2000-2004, includes the promotion and monitoring of reproductive rights as part of the overall United Nations response to upholding human rights instruments. The UNDAF has identified four development challenges: governance and human rights; equity and poverty reduction; economy and employment; and population and basic social services. Four corresponding strategic objectives have been delineated, one of which is the protection of basic social services. In this regard, UNDAF underlines HIV/AIDS prevention, health and education as key priorities. UNFPA and UNESCO have been designated as lead agencies, on a rotation basis, for the population and basic social services area.

4. The long-term goals of the Government of Zimbabwe are in harmony with the Programme of Action of the International Conference on Population and Development (ICPD). The overall goal of the National Population Policy is to achieve a higher standard of living for the people of Zimbabwe. The specific goals include: the provision of reproductive health services for all; the achievement of gender equity and the integration of disadvantaged groups into the mainstream of development; and the promotion of adolescent health with particular emphasis on reproductive health. In the health sector, the Government aims to achieve equity and quality in health care. Towards that end, health-sector reform and decentralized health service delivery, including reproductive health services, are being promoted to help ensure improved and expanded access to

comprehensive and effective services. UNFPA would collaborate in the further development of the health sector reform and the decentralization of health service delivery.

5. The goal of the proposed programme would be to contribute to the Government's aim to improve the quality of life through better reproductive health services and education, and the improved status of women. UNFPA support would be channelled through two subprogrammes, one in reproductive health and the other in advocacy. Gender considerations would be mainstreamed in both subprogrammes. In the area of population and development strategies technical assistance would be provided.

6. The proposed programme was developed within the framework of a human rights approach. All activities under the proposed programme, as in all UNFPA-assisted activities, would be undertaken in accordance with the principles and objectives of the ICPD Programme of Action, which was endorsed by the General Assembly in its resolution 49/128.

Background

7. The population of Zimbabwe is estimated at 11.8 million (1997)[1]. About 50 per cent of the population is under the age of 15. The population growth rate was estimated at 2.5 per cent in 1997 and it is believed to have declined mainly due to the HIV/AIDS epidemic. Approximately a quarter of the adult population is HIV-positive. The health sector is currently facing an unprecedented challenge mainly due to escalating economic difficulties and the HIV/AIDS epidemic. In addition to the significant increase in illness and mortality, AIDS has increased the number of orphans from an estimated 15,000 in 1990 to 150,000 by 1996. The number is expected to rise to about 1 million by 2005.

8. Prior to ICPD, Zimbabwe had already achieved the threshold levels of four out of the seven indicators used for measuring progress towards some of the key goals of the ICPD Programme of Action. The three remaining indicators for which threshold levels have yet to be reached pertain to the maternal mortality ratio, the infant mortality rate and the contraceptive prevalence rate. However, achievements made before ICPD have been eroded and the reproductive health status of Zimbabweans has deteriorated. The total fertility rate has stagnated at 4.4 children per woman since 1992. While efforts in family planning have resulted in universal awareness of modern contraceptive methods, the contraceptive prevalence rate for all methods has remained at 42 per cent since 1992.

9. The 1994 Demographic and Health Survey indicated that about 45 per cent of girls become mothers by the age of 19. A 1997 survey by the Zimbabwe National Family Planning Council (ZNFPC) indicated that 55 per cent of all youth pregnancies were unwanted and that 80 per cent of pregnant girls had to leave school. In 1997, 19 per cent of youth between the ages of 20 and 24

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[1] *Unless otherwise indicated, the data in the text are from governmental sources and may vary from data in the fact sheet.*

years and 14 per cent of youth between the ages of 15 and 19 years were reported to have had sexually transmitted diseases (STDs). In 1995, 28 per cent of girls between the ages of 15 and 17 years who attended a Harare antenatal clinic tested HIV-positive. However, most youth do not appear to see themselves at risk of early pregnancy, STDs or HIV.

10. The family planning programme in Zimbabwe is relatively well developed, and ZNFPC, a parastatal organization under the Ministry of Health and Child Welfare, is in charge of promoting and coordinating family planning activities including family planning advocacy, evaluation, training and information, education and communication (IEC). ZNFPC is also responsible for contraceptive procurement and distribution. About 1,200 public-sector clinics and hospitals provide family planning as an integral part of maternal and child health (MCH) care. Under the proposed programme, ZNFPC plans to integrate the reproductive health concept in its activities.

11. Soon after ICPD and the Fourth World Conference on Women, a Gender Division was established in the Office of the President and Cabinet, and gender units were set up in some sectoral ministries. Zimbabwe has ratified the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and is signatory to the Southern African Development Committee (SADC) protocol on gender. In 1997, the Government took measures to remove the Minority Age Act under which women were considered permanent minors. However, despite policy and legislative measures taken by the Government, Zimbabwean women are frequently denied their social and economic rights due to the ways in which family and customary laws may be interpreted.

Previous UNFPA assistance

12. UNFPA has provided assistance to Zimbabwe since 1982. The third programme of assistance for Zimbabwe was approved in 1996 for a period of four years, in the amount of $8.9 million, of which $2.5 million was through co-financing modalities and/or other resources. Under co-financing modalities, the Governments of Norway and the Netherlands contributed approximately $1 million for strengthening the health delivery system. Of that amount, $0.6 million has been expended. Estimated expenditures under the third country programme amount to $6.6 million, of which $6.0 million would be from regular resources.

13. Programme achievements include the following: strengthening of reproductive health services under the Ministry of Health and Child Welfare; integration of population education, including information on HIV/AIDS prevention and reproductive health, in the curricula of primary schools and 15 teachers colleges; capacity building through the provision of 18 scholarships for studies in health management leading to the Master of Public Health degree; and strengthening of community-based contraceptive distribution. In addition, pilot undertakings in post-abortion care and post-partum hospital-based family planning services proved successful, as did peer-education programmes supported in two provinces. A survey on the post-abortion pilot initiative indicated that clients treated at the pilot centres avoided repeat abortions and repeat pregnancies. An in-depth evaluation of the peer-education programme noted that the programme activities had benefited the target population and had helped to create a positive attitude towards responsible sexual behaviour.

14. Among the constraints encountered by the programme were delays in programme development and implementation. Also, the aim of contributing to a reduction in maternal mortality was not achieved, mainly due to the HIV/AIDS epidemic, a rise in poverty in the country, and budgetary and manpower constraints in the health sector. While the programme emphasized national execution, national capacity in that area was limited. Under the proposed programme, it is expected that National Professional Project Personnel (NPPP) would be utilized to facilitate programme implementation.

15. The key lessons learned from past programmes include the following:

(a) peer education and community-based approaches are an effective means of bringing reproductive health information to people in their homes, neighbourhoods and workplaces. The provision of reproductive health information and services in the workplace is vital for increasing male involvement in family planning and HIV/AIDS prevention, including condom use;

(b) awareness and knowledge of reproductive health and HIV/AIDS issues do not necessarily induce behaviour change. Socio-cultural research on determinants of risky sexual behaviour and the design of IEC and advocacy strategies that incorporate such research findings are needed;

(c) participation in reproductive health activities and adolescent reproductive health (ARH) is higher when combined with income-generation/vocational training for youth. This underscores the fact that economic empowerment is at the top of the hierarchy of youth needs;

(d) containing the HIV/AIDS epidemic requires a sustained and focused public-health approach grounded in the highest level of political commitment, priority investment and social support, otherwise the progress achieved in implementing the ICPD Programme of Action will disappear.

Other external assistance

16. UNICEF, UNDP, WHO and UNESCO have programmes in the health and education sectors. In addition to supporting child rights and social policy, UNICEF has focused on child and women's health, health-care management and community health. Part of its support was extended to out-of school-youth programmes and life-skills programmes in schools. UNDP support has focused on poverty alleviation, drought preparedness, land-policy support, employment creation and enhancement of women's participation in decision-making. The major activities of WHO include the prevention of communicable diseases, health promotion and support for the essential drugs programme. UNESCO activities have included HIV/AIDS education in schools, adult education and youth programmes. The World Bank provides support for health infrastructure and the procurement of medical supplies, including drugs for STD treatment, and equipment.

17. A number of other donors are supporting health and education efforts in Zimbabwe. The Canadian International Development Agency (CIDA) supports NGOs working in the area of

HIV/AIDS. Danish International Development Assistance (DANIDA) assists the Ministry of Health and Child Welfare with health-sector reform, the decentralization of laboratories, the health information system, essential drugs and HIV/AIDS-prevention activities. Support from the Department for International Development (DFID) of the United Kingdom has focused on health-policy development and planning and the social marketing of condoms through Population Services International (PSI). DFID also provides ZNFPC with condoms and supports the strengthening of health management through a World Bank project. Support from the Government of the Netherlands focuses on HIV/AIDS prevention. The Norwegian Agency for Development (NORAD) supports health decentralization efforts and the National AIDS Prevention Programme. The Swedish International Development Cooperation Agency (Sida) has provided support for community-based rehabilitation, nutrition, health education for farm workers and gender awareness campaigns. The United States Agency for International Development (USAID) has supported the social marketing of condoms, the provision of contraceptives and a pilot programme in voluntary HIV testing and counselling. The Australian Agency for International Development (AusAID) supports NGOs working in the area of HIV/AIDS prevention.

Proposed programme

18. In line with the overall goal noted in paragraph 5, and in view of the threat posed by the HIV/AIDS epidemic and the reversal of many past achievements in the health sector, the proposed programme would give reproductive health and related advocacy top priority. Building on the success of initiatives undertaken in the previous programme, for example, the pilot projects on post-partum and post-abortion care and peer education in workplaces and communities, the proposed programme would channel UNFPA assistance through two subprogrammes in the areas of reproductive health and advocacy. The recommendations of the CPA, inter alia, identified issues in the area of population and development strategies (PDS) that require donor assistance. However, in the light of current priorities and limited resources, UNFPA assistance in the area of PDS would be limited to technical advisory services for the 2002 census, to be provided by the UNFPA Country Support Team (CST) based in Harare. In addition, a project under the Fund's proposed regional programme for sub-Saharan Africa would strengthen capacity to undertake censuses; harmonize data collection and dissemination systems; and standardize census operations in the SADC countries.

19. Within the context of UNDAF, UNICEF and UNFPA would jointly support, inter alia, adolescent reproductive health, school-based peer education and counselling, and youth policy formulation. In addition, UNFPA, UNICEF and WHO would jointly support strengthening emergency obstetric care; operational research in reproductive health; and a pilot initiative in the prevention of mother-to-child transmission of HIV/AIDS. Along with other members of the United Nations country team, UNFPA would jointly support a multi-sectoral advocacy campaign for the prevention of HIV/AIDS and the promotion of gender equity and equality and reproductive rights.

20. Reproductive health subprogramme. The purpose of the reproductive health subprogramme would be to contribute to increased utilization of integrated quality reproductive health services by women, men and adolescents. The challenge for population and health programmes lies not only

in making reproductive health accessible and affordable but also in changing social norms, behaviours and attitudes that inhibit the use of reproductive health services. To contribute to such behaviour changes, research-based and gender-sensitive IEC would be an integral part of reproductive health interventions. The subprogramme would focus on delivering three outputs.

21. The first output would be strengthened national capacity to deliver integrated quality reproductive health services. To achieve this, at the national level, support would be provided for the operationalization of the reproductive health concept through upgrading clinical service guidelines and protocols, and developing and incorporating integrated training modules in pre-service and in-service training curricula for health personnel. Capacity for the implementation and management of reproductive health programmes would be enhanced through the training of trainers in management, supervision and monitoring. A reproductive health database disaggregated by sex would be established. Four provincial family planning and MCH training institutions would be upgraded to become reproductive health training centres, and district health personnel would be trained in the delivery of reproductive health services. To decrease repeat abortions and unwanted pregnancies, guidelines for post-abortion care would be developed and efforts would be undertaken to extend the institutionalization of post-abortion and post-partum family planning from 4 to all 10 provincial hospitals.

22. The second output of the subprogramme would be improved access to reproductive health information, education and services for adolescents and youth. Specific interventions to increase youth participation and involvement would be supported. At the national level, the formulation of a youth policy would be supported. In 26 out of the country's total of 58 districts, ARH services would be expanded through the public-health delivery system and NGOs. Current ARH services provided through the public sector would be assessed and expanded from 7 to 16 districts. Similarly, ARH services provided through NGO clinics and youth vocational programmes would also be assessed, strengthened and expanded from 5 to 10 service delivery points in 10 districts. As a result, the 26 most disadvantaged districts would be reached. A complete package of ARH services would be provided mainly to youth in the age-group of 15-19 years with an emphasis on education on human sexuality and STD/HIV prevention, while youth between the ages of 10-14 years would benefit from the IEC and counselling through in-school programmes. District-level health personnel would be trained in youth counselling and ARH service provision, and four voluntary counselling and testing centres for STDs would be established for youth in areas of high population density.

23. The third output of the subprogramme would be increased understanding of reproductive health and gender issues, which in turn would help to influence positive behaviour change. Support would be provided for the formulation and operationalization of a comprehensive IEC strategy focusing on reproductive health, including sexual health, family planning, and STD/HIV/AIDS prevention, and reproductive rights. Training in developing and disseminating IEC materials would be provided to strengthen staff capacity in key institutions. The development of IEC materials in support of reproductive health, including youth-targeted and gender-sensitive curricula, would be integrated in the four provincial family planning and MCH training institutions mentioned above. Special efforts would be made to reach men through community- and workplace-based peer-

education programmes. Such programmes are ongoing in two provinces, Bulawayo and Mutare, and would be expanded to three other provinces selected in consultation with national authorities. Given the influence of religious institutions on the community, IEC in support of reproductive health would be integrated in the curricula of the United Theological College. Also, it is proposed that school-based counselling and peer-education programmes be established in 18 secondary schools: counselling guidelines would be upgraded; a guide on reproductive health for parents would be developed; and peer educators would be trained.

24. The successful implementation of the reproductive health subprogramme would depend on the Government's commitment to reproductive health, particularly to HIV/AIDS prevention, and its ability to retain trained personnel in the public-health sector.

25. The amount of $15.0 million would be allocated to the reproductive health subprogramme, $8.5 million of which would be sought through co-financing modalities and/or other resources. UNFPA has initiated consultations with potential donors and there are indications that funding may be available from private foundations for adolescent reproductive health and HIV/AIDS prevention.

26. Advocacy subprogramme. The purpose of the advocacy subprogramme would be to contribute to enhanced leadership and support for population and health issues from district councils, development committees, parliamentarians and women's and youth groups. This would result in increased commitment to implement the National Population Policy, especially in the areas of gender equity and equality, the empowerment of women, reproductive rights and HIV/AIDS prevention. The subprogramme would focus on delivering two outputs.

27. The first output would be an enhanced environment favourable to the implementation of reproductive health and population programmes. To that end, an advocacy strategy would be developed. Support would be provided for the operationalization of the Population Forum which is composed of key technical ministries, NGOs and the Council of Churches. The Forum would coordinate advocacy efforts. In addition, a parliamentarian support group for population and health would be established, inter alia, to review and address legislation that inhibits gender equity and equality and adolescents' access to services. The parliamentarian support group and the Population Forum would lead advocacy efforts for increased support to reproductive health programmes and the implementation of the ICPD Programme of Action. Programme support would also be provided for the nationwide dissemination of reproductive health and youth policies to key ministries and youth organizations. Seminars, workshops and conferences for political and community leaders, policy makers, planners and managers would be organized.

28. The second output of the subprogramme would be strengthened capacity to advocate for reproductive health issues, including HIV/AIDS prevention, adolescent reproductive health and gender equity and equality and empowerment of women. An advocacy network composed of, among others, district councils, development committees, women's, youth and religious organizations and the media would be supported. It is expected that 50 district councils and development committees would adopt action plans and participate in the advocacy interventions.

The advocacy network would spearhead advocacy for the prevention of HIV/AIDS and mobilize support for gender equity, equality and reproductive rights. A media forum would be supported to expand IEC and advocacy efforts. Consensus on reproductive health and ARH services would be built among key actors, including religious leaders, in order to influence a larger segment of the population. Media involvement would be sought to promote preventive health and responsible sexual behaviour.

29. The amount of $2.5 million would be allocated to the advocacy subprogramme, $1.5 million of which would be sought through co-financing modalities and/or other resources. UNFPA has initiated consultations with potential donors and there are indications that funding may be available from private foundations.

30. If funds become available through co-financing modalities, many activities would be expanded. For example: (a) the ARH initiative would have national coverage instead of being limited to 26 districts; (b) content on human sexuality, HIV/AIDS, gender, population and human rights would be integrated in the curricula of teachers' colleges and secondary schools and in the education programmes for out-of-school youth; (c) school-based peer-education and counselling would be extended to at least 75 secondary schools; (d) community and workplace-based peer education would be extended to 8 provinces instead of 5 provinces; (e) the outreach mechanism would be strengthened through upgraded training on contraceptive provision, STDs/HIV/AIDS and antenatal care for all 800 community-based distributors; (f) advocacy for HIV/AIDS prevention would be intensified at the national level; and (g) social mobilization to establish the advocacy network would be enhanced.

Programme implementation, coordination, monitoring and evaluation

31. The proposed programme would be implemented by key technical ministries and national and international NGOs. Based on a capacity assessment of selected institutions, UNFPA would step up efforts to build implementing capacity and would also promote national execution of programme components. The primary responsibility for programme coordination would rest with the Government and, in particular, with the National Economic Planning Commission and the Ministry of Health and Child Welfare.

32. In the context of CCA and UNDAF, information exchange would be ensured through regular inter-agency meetings and the inter-agency thematic groups. As one of the lead agencies in the area of population and basic social services, UNFPA would seek to ensure coordination among the United Nations agencies, other donors and NGOs working in the area of reproductive health and gender empowerment. UNFPA-supported reproductive health activities would also be coordinated with those supported by other donors such as NORAD, the Government of the Netherlands, USAID, PSI, Sida, and the World Bank.

33. Programme implementation would be monitored and evaluated in accordance with established UNFPA guidelines and procedures. The collection of baseline data and the development

of a reproductive health database would allow monitoring of progress. To the extent possible, joint evaluation and monitoring would be undertaken for the areas covered jointly by UNFPA, UNICEF and WHO. In addition to the annual reviews of subprogrammes, a mid-term programme review in 2002 and an end-of-programme evaluation in 2004 are envisaged. Technical backstopping would be provided by national experts and the Country Support Team based in Harare.

34. The UNFPA country office is composed of a Representative, one Assistant Representative, one National Programme Officer and General Service staff. Currently, the office also has the services of one Junior Professional Officer. National Professional Project Personnel would be utilized to support the substantive management of subprogrammes.

35. Under the proposed programme, the amount of $0.5 million from regular resources would be allocated for programme coordination and assistance.

Recommendation

36. The Executive Director recommends that the Executive Board approve the programme of assistance to the Government of Zimbabwe, as presented above, in the amount of $18 million, over the period 2000-2004, $8 million of which would be programmed from UNFPA regular resources to the extent such resources are available, and the balance of $10 million would be sought through co-financing modalities and/or other, including regular, resources to the extent possible, consistent with Executive Board decision 96/15 on the allocation of UNFPA resources.

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